Medical Report (3)

Re: Wayne Douglas – Benzodiazepine Dependence

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Prepared for: Tokyo High Court

Date: 7/4/10

Signature: .....

Contents

Introduction

I understand there have been some discrepancies regarding the following:

1. The application of the DSM IV-TR in relation to the evidence
2. Shortfalls in prescription doses
3. Possibility of anxiety disorder
4. Consistency of previous reports in relation to evidence (patient files)

Subsequently, this report serves to address each of these.

After having had the opportunity to view the transcripts of Wayne's patient files that were provided to me by Wayne, I can confirm that the content of these files does not alter anything as far as maintaining the dependence diagnosis is concerned.

Before outlining the reasons why, I would like to take this opportunity to make it clear to all relevant parties that my objective regarding Wayne's case is simply to determine whether he was dependent. My objective does not involve diagnosing the cause of his original complaint, whether it be Sylvian Aqueduct Syndrome (indicated by Dr. [redacted]), or an "Acute Vestibulopathy" (suspected by Neurologists, Dr. [redacted] and Dr. Hutchinson), neither of which has any bearing whatsoever on the dependence diagnosis. In addition, I would like to make it clear that the argument over whether Wayne had an anxiety disorder (Autonomous Nervous Disorder) does not for grounds for ruling out dependence.

This report consists of 3 sections as follows:

1. Background Information
2. DSM IV-TR & Patient Files
3. General

Section One is based on background information to give a better insight into the nature of Benzodiazepines and how dependence is formed and diagnosed.

Section Two is based fundamentally on the evidence in relation to the DSM IV-TR Criteria.

Section Three is also based on the evidence, but includes rationale with regards to the disputes over the shortfalls in prescription doses, differential diagnosis etc. and other general information.

The reference numbers to evidence items lodged in the court were provided to me by Wayne and his lawyer and I have not been able to verify them firsthand, however, I trust they are consistent with the court records.

Section One

1.1 Characteristics of Benzodiazepines

1.1.1 Benzodiazepines can be very effective for treating a number of acute anxiety conditions, especially where the patient has been exposed to sudden or serious trauma. However, Benzodiazepines soon lose their effect and for this reason it is recommended that they are not prescribed for any longer than about 2~4 weeks.

1.1.2 Also, they do not mix well with other drugs, and they should not be used in multiple combinations with each other, and subsequently, it is recommended that no more than one kind is prescribed at a time, otherwise, there is an increased possibility of side-effects and dependency forming.

1.1.3 As Benzodiazepines are very effective for short term treatment, patients will likely experience an initial settling of symptoms soon after the treatment begins. However, if the treatment is prolonged, it is likely that the patient's body will neuro-adapt i.e. develop tolerance. When this happens the drugs lose their therapeutic effect and patients may notice a return in some of their symptoms that were initially suppressed.

1.1.4 The symptoms can often be contained by increasing the dosage amounts; however, this usually escalates the state of tolerance and increases the likelihood of withdrawal symptoms occurring and is best avoided.

1.1.5 In cases where the treatment continues long term (anymore than a few months), the patient becomes more tolerant of the drugs and dependency can be formed. This can result in withdrawal symptoms occurring during the course of treatment, as well as when the patient begins to reduce. Some patients can experience a Protracted Withdrawal Syndrome, which can last for over a year.

1.2 Diagnosing Benzodiazepine Dependence

1.2.1 When diagnosing Benzodiazepine dependence, it is common practice to use the DSM-IV TR, which is the standard used by the American Psychiatric Association. As noted in the DSM-IV TR, drug dependence is a maladaptive pattern of drug use leading to clinically significant impairment or distress, which is manifested by 3 or more of the 7 Criteria occurring at any time in the same 12 month period.

1.2.2 When applying these criteria, it is not a simple case of looking at each of them individually. Rather, they should be looked at in a way that considers their relationship to one another within context of the overall clinical picture.

1.2.3 Also, when doing a symptom's analysis, it is not a simple case of saying that the original symptoms must have been due to anxiety and that the new symptoms must have been due to dependence. It is not that simple and clear cut. Quite often symptoms of withdrawal consist of original symptoms changing in nature, frequency and intensity; e.g. worsening of symptoms. Further, Benzodiazepine dependence often mimics the very same symptoms the drugs are intended to treat.

1.2.4 Subsequently, it must be made clear that a dependence diagnosis cannot be made on a symptoms analysis alone, although, certain symptoms patterns do act as useful indicators for specific conditions such as tolerance and withdrawal. Rather, symptoms should be considered within context of the overall clinical picture.

1.3 Prescription Duration / Dosages & Patient Files

1.3.1 The content of Dr. [redacted]'s patient file clearly shows that he prescribed Wayne a mixture of 5 different drugs, including 3 different Benzodiazepines and a Tricyclic antidepressant, which continued for almost a 7 month period without any change in dosage. This regime was then prolonged with new prescriptions of Benzodiazepines, which included 2 different kinds, after Wayne sought alternative treatment at the [redacted] in January 2001.

1.3.2 Subsequently, before we even begin to consider the content of Wayne's patient files, his symptoms, the overall clinical picture and the application of the DSM-IV TR, we can already determine that there was at least a 50~100% chance that he was dependent simply based on the duration and dosages of his prescriptions alone.
NB: The reason for the wide range in possibility of dependence is because individuality needs to be considered.

Section Two

2. DSM-IV TR & Patient Files

2.1 Tolerance (1)

Based on the evidence outlined in Article 1.3 above, we know that the prescription doses and duration were sufficient enough for Wayne to have formed tolerance. Further to the reference given on Page 13 of my first report, Professor Ashton has provided the following information: "*Tolerance and dependence can develop if benzodiazepines are used regularly for longer than 2-4 weeks. There is no minimum dose, for example tolerance and dependence have been observed after the regular use of 2.5-5mg of diazepam.*"

NB 1: We must also consider that the rate and degree to which tolerance forms is different for each individual and this is the reason why close monitoring is so important.
NB 2: It is possible to form tolerance on both long and short acting agents.

The fact that Wayne produced withdrawal symptoms upon reduction at our service in April 2001 confirms that he had developed tolerance.

NB: As outlined in my second report, dated 23rd December 2008, withdrawal and tolerance are interrelated because if a patient does not have tolerance, then there is no neuro-adaptation, and thus no withdrawals will occur.

Subsequently, the only question is when did he first develop tolerance and what were the signs.

Tolerance can be made apparent by the following signs:

1. Resurfacing and/or worsening of original symptoms
2. Failure of drugs to contain illness long term
3. Development of withdrawal symptoms during treatment (See Article 2.2)
4. Development of withdrawal symptoms upon reduction (See Article 2.2)

(1) Resurfacing and/or Worsening of Original Symptoms

2.1.1 The content of Dr. [redacted]'s patient file shows that Wayne was complaining of neck and back pain upon initial presentation on 30th June 2000 (See page 11 – Wayne's hand written note).

2.1.2 The content of Dr. [redacted]'s patient file shows the following entry made on 19th July 2000 "Shoulder ache, muscle tension on neck - None" (See page 8).
NB: This is consistent with reports from Wayne upon presentation to our service saying that he experienced an initial settling of symptoms following the first 2 or so weeks of his treatment. Other symptoms that Wayne reported settled initially and then worsened again included his feelings of anxiousness and dizziness.

2.1.3 The content of Dr. [redacted]'s patient file does not contain Wayne's handwritten note, dated 21st August 2000, however, I understand that it has been entered into the evidence (Evidence Koh A12-1) and that it reads as follows:

No.	Content	Status	Consistent with
	30 June 2000 (Symptoms)		
1	Continuing disequilibrium (especially feel queasy when washing dishes, taking shower)	Continuing	
2	Lethargy and fatigue (still the same)	Continuing	
3a	Shortness of breath (little improvement)	Improved	Therapeutic effect
3b	Palpitations	New	Tolerance / withdrawal
4	Eyes feel like they're swimming (now, only at mornings)	Improved	Therapeutic effect
5	Legs feel weak (they momentarily came right, but now can't seem to get much strength into them	Improved then Worsened	Tolerance
6	Feel out of kilter	Continuing	
	(Other)		
7	Summer lethargy		
8	Stress & fatigue	Continuing	
9	Stiff shoulders	Improved then Worsened	Tolerance
10	Hemorrhoids have worsened		
11	Ulcers in mouth	New	Side-effects
12	Lost appetite	No improvement	Tolerance

2.1.4 The symptoms in this handwritten note are consistent with reports from Wayne upon presentation to our service saying that after his initial settling of symptoms, he experienced a short period of little change, but following about 1.5 months of Benzodiazepine based treatment, he noticed that he had: (1) continuing symptoms, (2) worsening symptoms and (3) some new symptoms as well.

2.1.5 The continuing of symptoms is apparent in numbers 1, 2, 6, 8 in the above list.

2.1.6 The exception is that there appeared to be some improvement in 3a, 4 at this point in time. NB: Tolerance does not always form across all symptoms.

2.1.7 The worsening of symptoms is apparent in numbers 5, 9 in the above list.
NB: According to Dr. [redacted]'s patient file, Wayne's initial complaint of neck and back pain had disappeared after about 2 weeks of treatment (See page 8), but the above list suggests that this had returned. Wayne's other comment saying that the feeling of weakness in his legs momentarily came right, but then worsened again is of a similar pattern in that it improved initially and then worsened again.

2.1.8 The development of (notable) new symptoms is apparent in the listing of "Palpitations". I note that there is no previous mention of this either in Wayne's handwritten notes or in any of the other patient files prior.
NB: I can confirm that this is consistent with withdrawal type symptoms.

(2) Failure of Drugs to Contain Illness Long Term

2.1.9 The fact that Wayne showed an initial settling of symptoms followed by the return of certain other symptoms along with the development of new symptoms (See Articles 2.1.3 & 2.2.3) suggests that he had started to develop the early stages of tolerance following about 1.5 months of Benzodiazepine based treatment, and subsequently, this shows that the drugs were not achieving the desired result of containing Wayne's symptoms long term.

2.1.10 I have been informed that Dr. [redacted] is claiming Wayne had made a full recovery as a result of his drug treatment whilst under his care. However, the Patient Questionnaire Form on page 2 of the [redacted] Medical Centre patient file shows that Wayne was still suffering from various symptoms including his original complaint of dizziness (Evidence Koh A6), as was the case when he presented to our service in April 2001.

2.1.11 Taking into consideration the above, and due to the fact that Wayne experienced withdrawal symptoms upon reduction (personally observed by myself), we can conclude that his body had neuro-adapted and therefore, we can also conclude that he had developed tolerance.

Conclusion: Wayne meets the DSM-IV TR criteria for "Tolerance".

2.2 Withdrawal (2)

Withdrawal can be made apparent by the following:

1. Worsening of original symptoms (frequency, intensity, nature) during treatment
2. Development of new symptoms during treatment
3. Worsening of symptoms (frequency, intensity, nature) upon reduction
4. Development of new symptoms upon reduction

(1) Worsening of Original Symptoms During Treatment

(Muscle Stiffness)

2.2.1 The worsening of original symptoms during treatment was apparent in the complaint of muscle stiffness. Wayne's handwritten note (Evidence A12-1) shows that he experienced a worsening in muscle stiffness (See article 2.1.3) after this symptom initially settled (See page 8 of Dr. [redacted]'s patient file). I have been informed that Wayne began a course of massages from November 2000 at a local physiotherapy clinic in Saitama to help try and alleviate this.

2.2.2 Wayne's handwritten note (Evidence Koh A26) shows that this muscles stiffness came to include a significant tightening in his jaw, which led to him not being able to close his mouth properly following about 4 ~ 6 months of Benzodiazepine prescriptions.

Also contained in this list was "pains in joints". This is supported by the fact that after returning to New Zealand, Wayne consulted the Dental Department here at Taranaki Base Hospital and was diagnosed with Temporo Mandibular Disorder, or TMD.

NB: In the Q & A document, between Mr. [redacted] and me, dated 19th December 2008, I said that I was unable to comment further on some of Wayne's symptoms including the muscle stiffness. This is because further information was needed at the time in order to be able to make a more objective decision. However, now that I have had the opportunity to view the patient files firsthand, and to consider this in context, I can confirm that the muscle stiffness is consistent with withdrawal.

(2) Development of New Symptoms During Treatment

2.2.3 The content of Dr. [redacted]'s patient file (See page 29) shows the first 4 symptoms contained in Wayne's handwritten note (Evidence Koh A26), as shown below.

No.	Content	Status	Consistent with
	18 December 2000 New Symptoms		
1	From November, started to experience light tinnitus (when trying to sleep and upon wakening in the mornings)	New episode	Withdrawal
2	Developed what appears to be a smear on the lens of my eyes (cataract?) (in right eye, can be seen even after eye is closed) From October	New	Vitreous Opacities
3	Became sensitive to heat (body temperature seems to change all the time)	New	Side-effect / Withdrawal
4	Pulse rate is higher than usual	New	Side-effect
5	Flushes	New	Withdrawal
6	Loss in sexual interest	New	Side-effect
7	Developed habit of closing eyes all the time	New	
8	Starting to feel detached	New	Withdrawal
9	Pressure in the chest	New	Withdrawal
10	Occasional stomach pains	New	Side-effect
11	Loss in appetite	No improvement	Side-effect / Withdrawal
	Symptoms I Forgot to Write Previously		
12	Pain in jaw	New	Withdrawal
13	Often got mouth abrasions during childhood		
14	Often suffered from motion sickness during childhood		
15	Pains in joints	New	Withdrawal
16	I smoked marijuana between 15 and 21 and experienced a sense of paranoia for a time	(See Article 1.2.3 of first report)	
17	Lost 10 kilos in weight	No improvement	Withdrawal
18	Inside of head twitches and pulsates	No improvement	Withdrawal?
19	Once had allergic reaction to Tiger Balm and developed a nettle rash		

NB: I understand that the above handwritten note was initially given to Dr. [redacted] only in partial form on 25th December 2000 at Wayne's final consultation. I have been informed that, although, Wayne complained of all these symptoms verbally, he decided to add to the partial version of the list whilst waiting in the waiting room with the intention of showing it to Dr. [redacted], or the nursing staff, in order to convey his condition more clearly. Wayne reports that he did not have the opportunity to show the completed list to Dr. [redacted] as intended, and that he showed it to Dr. [redacted] on 22nd January 2001 instead.

2.2.4 Symptoms of interest in the above list include; tinnitus, sensitive to heat (hypersensitivity), pulse rate (tachycardia), flushes, loss in sexual interest, feelings of detachment (emotional anaesthesia), pressure in chest, occasional stomach pains, jaw pain, joint pains. The content of all the previous patient files confirm that Wayne did not have these symptoms prior to commencing the Benzodiazepine regime. These symptoms are consistent with withdrawal type symptoms and/or side-effects.

2.2.5 The only symptom from (2.2.4) above that Wayne had prior to commencing the Benzodiazepine regime was tinnitus. The content of the [redacted] Hospital ENT patient file shows that Wayne complained of tinnitus following his initial vertigo attack in May 2000 (page 12). However, Wayne reports that this had rectified itself before his first consultation with Dr. [redacted] on 30th June 2000, which is supported by the fact that there was no mention of it again, either in Wayne's initial handwritten notes to Dr. [redacted], or indeed in Dr. [redacted]'s patient file either.

2.2.6 The fact that tinnitus developed for a second time, following 4~6 months of Benzodiazepines, is once again consistent with withdrawal type symptoms. Symptom escape (where symptoms of the original complaint resurface due to tolerance and lost drug effect) may also be suggestive.

2.2.7 The symptoms that were consistent with withdrawal and first developed during the course of Wayne's treatment were most likely secondary to the development of tolerance. As mentioned in my second report, however, it is most likely that Wayne's condition was due to a combination of these withdrawal symptoms together with other adverse effects, or symptom clusters, which is common in Benzodiazepine dependence. This is supported by Professor Ashton, who states the following:

"*When tolerance develops, "withdrawal" symptoms can appear even though the user continues to take the drug. Thus the symptoms suffered by many long-term users are a mixture of adverse effects of the drugs and "withdrawal" effects due to tolerance.*" (See Benzodiazepines: How They Work and How to Withdrawal. Prof. C. H. Ashton. Revised August 2002 – Chapter 2, Pages 2/10 of online version).

2.2.8 Further to my second report, dated 23rd December 2008 (which focused mainly on the possibility of breakthrough withdrawal symptoms occurring during treatment due to tolerance and oscillating plasma levels on short acting agents, such as Tofisopam), I would like to clarify that it is also possible for a patient to get "withdrawal" symptoms during treatment simply due to tolerance alone, even on long acting agents. This is because once a patient has developed tolerance; the same dose of Benzodiazepine may not exert the same effect, even if it produces the same plasma levels.

(3) Worsening of Symptoms Upon Reduction

2.2.9 As mentioned in my first report, Wayne met the criteria for withdrawal, which was made evident by the following symptoms. Some of these first emerged during the course of his treatment (See Article 2.2.3) due to tolerance and others appeared for the first time on reduction of his overall dose:

No.	Content	Status	Consistent with
1	Tingling sensation over face	New upon reduction	Withdrawal
2	Loss in coordination	New upon reduction	Withdrawal
3	Myoclonic jerks	New upon reduction	Withdrawal
4	Oily smell in body odour (increased hypersensitivity)	New upon reduction	Withdrawal
5	Increased joint pains	New during treatment then worsened upon reduction	Withdrawal
6	Tightening of muscles	Initially improved, then worsened during treatment and again upon reduction	Withdrawal
7	Worsening of dizziness	Initially improved, then worsened during treatment and again upon reduction	Withdrawal
8	Worsening of pulsating temporal arteries	Initially improved, then worsened during treatment and again upon reduction	Withdrawal
9	Worsening of visual disturbances	Initially improved, then worsened during treatment and again upon reduction	Withdrawal
10	Increase in emotional instability	Initially improved, then worsened during treatment and again upon reduction	Withdrawal
11	Increased palpitations	New during treatment then worsened upon reduction	Withdrawal
12	Tightening in chest	New during treatment then worsened upon reduction	Withdrawal
13	Flushing	New during treatment then worsened upon reduction	Withdrawal
14	Hypersensitivity	Initially improved, then worsened during treatment and again upon reduction	Withdrawal

2.2.10 Worsening of symptoms (frequency, intensity, nature) upon reduction is apparent in numbers 5~14 in the above list, as explained below.

(5.Increased Joint Pains, 6.Tightening of Muscles)

2.2.11 Further to Articles 2.2.1~3 above / pg 17 of my first report, a GP recommended that he undergo a course of acupuncture to help assist with the additional muscle stiffness that he was experiencing upon reduction with Dr. John Yuan (Evidence Koh C10-3).

(7.Worsening of Dizziness, 8.Worsening of Pulsating)

2.2.12 Further to page 17 of my first report, some of the first symptoms to worsen upon reduction included the worsening in dizziness and pulsating in temple areas.
NB: This is consistent with Dr. [redacted]'s observation during Wayne's 2nd (planned) attempt at reduction on 1st March 2001 (See page 10 of [redacted] patient file).

(9.Worsening of Visual Disturbances)

2.2.13 Further to page 19 of my first report, Wayne was concerned about his worsening of visual disturbances, and subsequently, upon our advice he arranged a follow-up examination with Ophthalmologist, Dr. Kevin Taylor, who suggested that the staggered vision may have been due to the Benzodiazepines slowing down visual signals to the brain.

(10.Increase in Emotional Instability)

2.2.14 Further to page 17 of my first report, we referred Wayne onto Clinical Psychologist, Alan Guy, for periodic consultations regarding the increase in emotional stability that he was experiencing upon reduction (Evidence Koh A18).

(11.Increased Palpitations, 12.Tightening in Chest, 13.Flushing)

2.2.15 Further to page 13 of my first report, Wayne complained that these symptoms, which first developed during the treatment (See Articles 2.1.3 & 2.2.3), worsened again upon reduction.

(14. Hypersensitivity)

2.2.16 Further to page 13 of my first report, Wayne complained of an increase in sensitivity to light and sound during the reduction process. Wayne reports that he often found TV programs with visual effects too overwhelming and the sound too loud compared with other normal people around him.

(4) Development of New Symptoms Upon Reduction

2.2.17 Development of new symptoms upon reduction is apparent in numbers 1 ~ 4 in the above list, as explained below.

(1.Tingling Sensation over Face)

2.2.18 As outlined on page 17 of my first report, Wayne experienced a tingling sensation over his face upon reduction (Paresthesia).

(2.Loss in Coordination)

2.2.19 As outlined on page 17 of my first report, Wayne experienced a loss in coordination, which is related to neuromotor dysfunction, and included arm and hand movements.

(3.Myoclonic Jerks)

2.2.20 As outlined on page 17 of my first report, Wayne experienced myoclonic jerks, which is a symptom of withdrawal observed in some people. (See Benzodiazepine Withdrawal: An Unfinished Story. Prof. C. H. Ashton. 1984, Page 9/13 of online version).

(4.Oily Smell in Body Odour)

2.2.21 As outlined on page 17 of my first report, Wayne experienced the sensation of emanating an oily smell in his body odor. This can be associated with an increase in hypersensitivity, where patients in withdrawal experience a heightened sensitivity to all sensations including hearing, sight, touch, taste and smell. (See Benzodiazepines: How They Work and How to Withdrawal. Prof. C. H. Ashton. Revised August 2002 – Chapter 3, Pages 7/22 of online version).

2.2.22 As outlined above, Wayne experienced the worsening of original symptoms and the development of new symptoms, which were consistent with withdrawal, both during the treatment (due to tolerance) and also upon reduction at our service.

Conclusion: Wayne meets the DSM-IV TR criteria for "Withdrawal".

2.3 Loss of Control (4)

2.3.1 The content of the [redacted] Medical Centre patient file shows that a reduction plan was put in place on 7th February 2001 (See page 10). In accordance with this reduction plan, Wayne attempted reducing his intake from 3 to 2 times a day from 1st March with a follow-up consultation directly after on 2nd March, which was probably scheduled to check on progress.

2.3.2 There is an entry on 2nd March recording the result of this attempt at reduction, as follows:
"(S) Pulsation on his temple (right-? not readable)
(O) Wondering if drug should be changed to 2 times (since the dizziness is increasing.)"

2.3.3 There is another entry in the patient file on 19th March, which reads; "Takes drugs 3 times / day".

2.3.4 This provides a clear record that Wayne's 2nd attempt at reduction (from 3 to 2 times a day), in accordance with Dr. [redacted]'s reduction plan, was unsuccessful because he had resumed in taking the doses 3 times daily.

2.3.5 There is another entry on 19th March stating "I am thinking of going off (the drugs) after return home".

2.3.6 This supports Wayne's statement saying that he made a 3rd unsuccessful attempt at stopping in late March 2001 after returning to New Zealand, but was unable to do so, and subsequently, sought help from Dr. Whitwell and later from our service.

Conclusion: Wayne meets the DSM-IV TR criteria for "Loss of Control".

2.4 Impact on Life (6)

2.4.1 The content of the [redacted] Neurology patient file says "Patient can continue ordinary work without any problem" (See page 17).
NB: This supports Wayne's claim that he was still able to work in Japan, albeit on light duties, before the Benzodiazepine treatment began and during the early stages of the treatment.

2.4.2 The letter from Dr. Whitwell shows that following more than 6 months of Benzodiazepine exposure, Wayne ended up in a state where he was unable to work at all again for a period exceeding one year (Evidence Koh A7).
NB: Wayne was only declared fit enough to return to work again after the drugs had been removed and after he had recovered from the initial withdrawal phase of his dependency.

2.4.3 The two statements submitted by Wayne's friends, Edward TeUa and Joseph Tait (who knew him well before, during and after his dependency problem), show that Wayne was suffering a loss in ability to socialize. Noted in these statements were aggressive tendencies; including an incident where Wayne stood up and made abusive comments to passengers on a shuttle bus in September 2000 and another when he became aggressive towards patrons at a café in late November, which was said to be out of character (Evidence Koh A14&15).

2.4.4 The statement submitted by Wayne's mother shows that he was experiencing relationship difficulties. Noted in this statement was Wayne's inability to communicate properly (in a way that was normally expected), inability to concentrate, extreme moodiness and mood swings, depression etc. Wayne reports that this instability caused his mother taking up smoking again for the first time in twenty years, which may also help to give some indication of the pressure that his condition was placing on their relationship at the time (Evidence Koh C4).

2.4.5 Wayne's 1st statement (Evidence Koh A22) shows that he was experiencing difficulties with romance (See pages 12 & 15). Noted in this statement was Wayne's loss in sexual interest, his tendency to say hurtful things and subsequent arguments with his girlfriend at the time ([redacted]).
NB: Wayne's handwritten note (Evidence Koh A26) also notes contains loss in sexual interest.

2.4.6 Wayne's 2nd statement (Evidence Koh A30) shows that he was experiencing a significant reduction in his ability to take part in recreational activities. Noted in this statement was the reluctance of a local gym to allow Wayne to become a member because he was still walking like a drunk and sometimes had to support himself by holding onto things (See Articles 22 & 25).

NB: Considering that Wayne was experiencing difficulty in walking, the social problems outlined above, and that he was suffering from both physical and psychological symptoms, it seems reasonable to conclude that he was also experiencing a loss in his ability to take part in normal activities.

2.4.7 As outlined above, Wayne experienced impairment on his ability to work, loss in ability to socialize, relationship difficulties, difficulties with romance, and a reduction in his ability to take part in recreational activities – showing a significant impact on his life.

Conclusion: Wayne meets the DSM-IV TR criteria for "Impact on Life".

2.5 Continued Use Despite Knowledge of Harm (7)

2.5.1 The content of Dr. [redacted]'s patient file shows that Wayne was the type of person who showed an ongoing awareness of his condition. This is apparent in his handwritten notes, both at first presentation and during the course of the treatment (See pages 11~13, 29).

2.5.2 The content of the [redacted] patient file shows that Wayne returned to the Neurology Department seeking a re-referral to another hospital in the quest for alternative treatment. This is consistent with showing awareness that the drug treatment under Dr. [redacted] may have been causing him harm.
NB: The timeframe of this re-referral request (13th Dec 2000) coincides with Wayne's first reported attempt at reduction (late November) and his handwritten note (18th Dec 2000), which all occurred within about 3 weeks of one another.

2.5.3 The content of the [redacted] Medical Centre patient file shows that Wayne had a desire to reduce, which is made clear where it says "wants to taper medication" (See pg 10).

2.5.4 The content of the [redacted] Medical Centre patient file shows that Wayne and Dr. [redacted] had negotiated a reduction plan. In accordance with this plan Wayne attempted reducing from 3 to 2 times a day, but was unsuccessful (See Article 2.3 - Loss of Control).
NB: This supports the fact that Wayne was aware the drugs may be causing him harm, but continued to take them 3 times a day because he was unable to stop.

Conclusion: Wayne meets the DSM-IV TR criteria for "Continued Use Despite Knowledge of Harm".

Section Three

3.1 Recovery

3.1.1 Wayne's recovery was made apparent by the following:

1. Recovery from symptoms
2. Ability to return to work
3. Ability to return to recreational activities
4. Ability to return to Japan

(1) Recovery from Symptoms

3.1.2 As outlined on page 12 of my first report, Wayne recovered from most of his symptoms within the first year of cessation with many symptoms subsiding within the first 3 months. NB: Wayne did continue to suffer from panic attacks, however, this needs to be analyzed taking into consideration the long term effects including; protracted withdrawal, the trauma of the dependence experience, and the additional pressures of his subsequent case for compensation.

(2) Ability to Return to Work

3.1.3 Dr. Whitwell declared Wayne fit enough to return to work in June 2002 (See Evidence Koh A7). After being declared fit enough to return to work, Wayne worked as an English teacher for Queen's Academy of English for 1 year (See Evidence Koh C5-2).

3.1.4 After ending the above employment contract, Wayne began working as a yardman for Placemakers for 1 year. This job involved handling bulk building supplies such as timber, cement, bricks etc (See Evidence Koh C5-4).

3.1.5 Wayne also worked as an adventure tour guide for Auckland Adventures. This job involved full day hiking tours, canoeing, snorkeling, horse riding, mountain biking, prolonged hours of driving etc (See Evidence Koh C5-7-2~21).

NB: Although, Wayne was able to make a return to employment, I understand he has been limited in his capacity to take on jobs that involve too much responsibility due to the panic attacks mentioned above, which was outlined in Psychologist, Alan Guy's letter, dated 27th April 2007 (See Evidence Koh A18).

(3) Ability to Return to Recreational Activities

3.1.6 Wayne's ability to return to recreational activities was made apparent in Article 3.1.5 above.

3.1.7 Following the reluctance of a local gym to allow Wayne a membership in 2001 (after he entered their training facility in an apparent state of poor health) Wayne began a physical training program, which over time resulted in significant gains in weight, strength and stamina. This is supported by the fact that he was able to maintain his capacity to work as an adventure tour guide and yardman outlined above.

(4) Ability to Return to Japan

3.1.8 Wayne's recovery was made further apparent by his capacity to return to Japan, which was quite a psychological barrier for him following his previous experience there, as outlined in Psychologist, Alan Guy's letter, dated 27th April 2007 (See Evidence Koh A18).

3.1.9 In summary of the above, Wayne's condition upon presentation to our service was such that he was unable to work and was suffering from a range of physical and mental symptoms with obvious weight loss and loss in strength. In comparison, following the completion of his reduction program at our service, he was able to make a return to both work and recreational activities. Further, he was able to return to Japan once again to live and work, and despite being under much greater stress there now with his current claim for compensation, I understand that he continues to maintain a much better state of health at this present time.

3.2 Shortfalls in Prescription Doses

3.2.1 I understand that there have been some discrepancies regarding the apparent shortfalls in prescription doses. Also, I have been informed that a decision was made suggesting that because of these shortfalls (particularly in November 2000, when there was a shortfall of about 15 doses/5days worth) Wayne must have had the ability to miss consecutive doses, and therefore, could not have been in a state of dependence.

3.2.2 However, in accordance with our diagnosis, the overall clinical picture, and the application of the DSM IV-TR, we know that Wayne was defiantly dependent.

3.2.3 In order to help clarify the potential for Wayne to have made it through the term of his treatment, despite being in a state of dependence, Wayne and his lawyer prepared an entire breakdown of every single dose administered to him under Dr. [redacted] and Dr. [redacted] during 2000 and 2001, which I have had the opportunity to view. Also, upon further consultation with Wayne, we were able to identify the following possibilities regarding the shortfalls.

1. The possibility that Wayne commenced his prescriptions incrementally.
2. The possibility that there were dosage surpluses from previous prescriptions, as there was in August 2000 (6 doses).
3. The possibility that a dosage surplus was accrued during the early stages, due to forgotten doses, which is not uncommon in cases of long term treatment (however, Wayne's ability to miss doses would have decreased with time as his dependency progressed).
4. Left over doses from attempts at reduction, as Wayne reports was the case in November.

3.2.4 After considering the above, I can confirm that it would have been possible for Wayne to have made it through the duration of his treatment, despite there being apparent shortfalls, and despite the fact he was dependent, by way of accruing a reserve surplus.

3.2.5 Given that Wayne meet 5 out of the 7 criteria of the DSM IV-TR, and given that it was possible for him to have made it through the treatment, despite there being apparent shortfalls in doses, this argument does not form grounds for ruling out dependence.

3.3 Differential Diagnosis (anxiety disorder)

3.3.1 I understand that Wayne was diagnosed with "Autonomic Nervous Disorder" by Dr. [redacted] at the [redacted] Medical Center, which I have been informed is a term commonly used in Japan to describe the suffering of psychosomatic symptoms caused by general life stresses / anxiety.

3.3.2 I also understand that there are two parts to the anxiety disorder argument, as follows:
1. That Wayne was suffering from symptoms associated with stress.
2. That Wayne was suffering from symptoms associated with a chronic anxiety disorder.
Before addressing each of these, I would like to clarify the terminologies below.

3.3.3 Generally, in English speaking countries, we do not use the term "Autonomic Nervous Disorder" to describe psychosomatic symptoms caused by general life stresses or anxiety conditions. It is more common to use the term "Anxiety". As noted in "Management of Mental Disorders fourth edition" (Published by World Health Organization). "The experience of anxiety is very normal – moderate levels of anxiety will improve performance and even high levels of anxiety will be appropriate when they are consistent with the demands of the situation.... Individuals with anxiety disorders have specific and recurring fears that they recognize as being irrational or unrealistic and intrusive."

3.3.4 Subsequently, in making this differential diagnosis, I have chosen to use the term "Anxiety Disorder" to include the range of disorders outlined in the DSM IV and also defined by WHO. These include: Panic disorder, Agoraphobia, Social phobia, specific phobia, Generalised anxiety disorder, obsessive compulsive disorder, post traumatic stress disorder, acute stress disorder, anxiety disorder due to a general medical condition, anxiety disorder not otherwise specified, adjustment disorder, unexplained somatic complaints and hypochondriacal disorder.

3.3.5 In Wayne's case I have excluded substance induced anxiety disorder because any anxiety symptoms Wayne potentially suffered from during the course of his treatment in 2000 ~ 2001 were likely to be secondary to the medication he was prescribed.

(1) Stress

3.3.6 Wayne has always made it clear that he had stress symptoms due to a stressful job in Shizuoka in late 1999 ~ early 2000, as outlined in Article 1.4.1 of my first report.
NB: I note these symptoms are also recorded on page 12 of the [redacted] ENT patient file and include fatigue / lethargy, pressure in temple areas, swelling of temporal veins, shortness of breath, although there was no mention of sweaty palms and racing / scattered thoughts.

3.3.7 Wayne reported to our service that most of these stress symptoms disappeared after changing jobs at the end of March 2000. However, there does not appear to be anything in the [redacted] Hospital ENT patient file to support this, although he did say on page 13 that he really liked his new job. He also said that he felt a bit tired from the first month's training. In particular, he became a bit woozy around the middle of April. I am unable to comment as to whether this wooziness was related to the stress of his previous job or whether there was a separate cause.

3.3.8 Based on the above, we must also consider the possibility that Wayne did not recover completely from the aforementioned stress symptoms before commencing his treatment under Dr. [redacted], as first believed.

3.3.9 In addition to the above stress related symptoms, Wayne has always made it clear that he had feelings of anxiousness over not being able to receive a clear diagnosis for his vertigo attack on 11th May 2000 and subsequent balance problem thereafter.

3.3.10 However, it must be made clear that even if Wayne still had the stress symptoms relating to his former job and anxiousness over not knowing what caused his vertigo attack, the presence of these symptoms do not detract from the fact that tolerance, withdrawal and dependency were formed for the reasons outlined in the DSM IV-TR above.

(2) Chronic Anxiety Disorder

3.3.11 I have been informed that there have been claims made suggesting Wayne's worsening of symptoms and development of new symptoms during the drug treatment was caused by a chronic inherent anxiety disorder, as opposed to dependency.

3.3.12 Below are indicators to suggest that Wayne did not have an inherent chronic anxiety disorder:

1. No previous history of psychological or neurological complaints, as explained in Dr. ter Haar's letter (Evidence Koh A19) and Dr. Alan Guy's letter (Evidence Koh A18)
2. No notable history of medical complaints whilst living in Japan for 3 years prior to 1999
3. Initial testing and diagnoses in Japan did not indicate an anxiety disorder
4. Anxiety disorder only diagnosed after Benzodiazepine exposure, as outlined in the [redacted] Medical Center patient file (Evidence Koh A6)
5. First developed mental instability only after Benzodiazepine exposure - including panic attacks, anxiety, depression, mood swings, aggression, confusion, feelings of going mad
6. There was no apparent increase in stressful events during the course of treatment (apart from the fact his condition was worsening and he did not know why)
7. Was declared unfit to work only after Benzodiazepine exposure, as outlined in Dr. Whitwell's letter (Evidence Koh A7)
8. Condition improved following completion of initial withdrawal phase (See Article 3.1)
9. Currently residing in Japan again and under more stress now with court proceedings, but maintaining better health

(3) Other Considerations

(Symptom Escape)

3.3.13 It could be argued that the 'returning / worsening of symptoms' during the treatment (Article 2.1.3) was due to symptom escape (where symptoms of the original complaint resurface). However, symptom escape also occurs as a result of tolerance and lost drug effect and therefore, this argument does not detract from the criteria of tolerance having been met.

(Illness Progression)

3.3.14 It could be argued that the 'new symptoms' during the treatment (Article 2.2.3) were due to illness progression. However, when put into context of the overall clinical picture, it becomes apparent that they were most likely due to withdrawal, as explained below:

1. There was no apparent increase in stressful events during the course of treatment
2. These new symptoms worsened again during the reduction program (symptom rebound) and then they all eventually eased off/disappeared once all Benzodiazepine prescribing was ceased.
3. These new symptoms were accompanied by other new withdrawal symptoms during the reduction program, which also eventually eased off/disappeared once all Benzodiazepine prescribing was ceased.

NB: The exception to symptoms improving after the drugs were ceased was the panic attacks, which I understand have continued on and off to a lesser degree, whilst improving over time. With regards to the panic attacks, we must also take into consideration the long term effects including protracted withdrawal syndrome, the trauma of the dependence experience, and the additional pressures of the subsequent case for compensation.

(Dependency Can Produce Anxiety Symptoms)

3.3.15 Further to the above, we must also consider that dependency can produce the very symptoms they are designed to treat, i.e. anxiety symptoms, as noted by Professor Ashton based on a clinical study below.

"It is impossible to say whether the previously apparently stable patients would have developed psychiatric symptoms in the absence of benzodiazepine treatment. Nevertheless, the initial appearance of symptoms after a period of regular benzodiazepine use, the fact that all patients developed similar symptoms irrespective of the psychiatric history, and the improvement after drug withdrawal, all suggest that the symptoms resulted from benzodiazepine use and not from an underlying anxiety neurosis. This view has also been expressed by Lader, Tyrer, and others.

The appearance of symptoms while the patients were still taking benzodiazepines suggests the development of tolerance. Symptoms of prolonged use are said to include loss of concentration and memory, decline in psychomotor performance, depression, and emotional anaesthesia. With the exception of emotional anaesthesia, which was experienced only by the two patients with a history of depression, all patients developed these symptoms. Nevertheless, while the patients continued to take benzodiazepines they had other symptoms associated with benzodiazepine withdrawal - namely, agitation, panic attacks, agoraphobia, hallucinations, flushing, sweating, gastrointestinal disturbances, muscle pains, paraesthesiae, and many others. In several cases increased benzodiazepine dosage had been prescribed with temporary alleviation of the symptoms." (See Benzodiazepine Withdrawal: An Unfinished Story. Prof. C. H. Ashton. 1984, Page 10/13 of online version).

(Pre-existing Symptoms)

3.3.16 It could be argued that many of Wayne's symptoms were pre-existing and were therefore not related to dependency and withdrawal; however, it is not that simple. This is because in the case of dependency, pre-existing symptoms will often change in nature, frequency and duration, which can help us to differentiate between the original complaint and the development of withdrawal. Below are some examples in Wayne's case.

3.3.17 Muscle stiffness – We know that Wayne already had muscle stiffness to begin, however, this changed in nature because, after it improved initially, it returned and worsened to the degree that his jaw began locking up, which is suggestive of withdrawal, as observed in a clinical study conducted by Professor Ashton below:

"*Pain in various parts of the body was prominent. Neck pain and occipital headache, pain in the limbs described as aching, bursting, or cutting, and pain in the jaw were all common and often severe. Many patients complained of toothache, and some had undergone extractions of apparently normal teeth. Edentulous patients also complained of "toothache." All patients at some stage complained of a metallic or unpleasant taste. Stiffness and weakness often accompanied the neck, limb and jaw pains. Tremor of the hands and jaw, and muscle fasciculation, particularly in the thighs, were noted in several patients; many complained of sudden jerks, particularly in the legs but sometimes affecting the shoulders and back. Myoclonic jerks were observed in several patients.*" (See Benzodiazepine Withdrawal: An Unfinished Story. Prof. C. H. Ashton. 1984, Page 8-9/13 of online version).

NB: According to Wayne's medical records (Dr. ter Haar) Wayne had a previous history of periodic lower back pain since straining his back lifting heavy lumber in March 1989 and he also had a history of periodic neck pain, which according to Wayne, first developed in late 1997 whilst doing prolonged desk work using a laptop computer with poor ergonomics (Miyazaki Local Government Office).

However, the nature of Wayne's muscle stiffness following 4~6 months of Benzodiazepine prescriptions was quite different in nature from the above, as Wayne began to experience jaw stiffness for the first time to the degree that he was unable to close his mouth properly. Further, Wayne reports that this muscle stiffness, which was previously limited to periodic episodes in the lower back and neck areas, came to encompass his entire body changing in nature from periodic to ongoing. Wayne reports that he subsequently developed the habit of massaging his thighs every evening at home.

This is supported by the fact that Wayne began a course of regular deep tissue massage from November 2000 at a local physiotherapy clinic in Saitama to help try and alleviate this. I have also had the opportunity to view an English transcript of the referral form from Dr. [redacted] to the above physiotherapy clinic in Saitama ([redacted] Physiotherapy Clinic), which says "has been suffering from increasing muscular tension in the upper rear region of his neck and shoulders".

3.3.18 Hypersensitivity – We know that Wayne already had light sensitivity following his vertigo attack, however, this sensitivity changed in nature upon withdrawal because Wayne reports that he found the visual effects and volume of TV programs intolerable compared to other normal people around him. Further, this hypersensitivity came to include sensitivity to smell, which was apparent in that he sensed he was emanating an oily smell from his body odor. This type of hypersensitivity is suggestive of withdrawal, as observed in a clinical study conducted by Professor Ashton below:

"*A characteristic feature of benzodiazepine withdrawal is a heightened sensitivity to all sensations - hearing, sight, touch, taste and smell. When extreme, these sensations can be disturbing. One lady had to stop all the clocks in the house because their ticking sounded unbearably loud; many have had to don dark glasses because ordinary light seemed dazzlingly bright. Some find that the skin and scalp becomes so sensitive that it feels as if insects are crawling over them. Heartbeats become audible and there may be a hissing or ringing sound in the ears (tinnitus). Many people complain of a metallic taste in the mouth and several notice strange, unpleasant, smells which seem to emanate from the body.*"
(See Benzodiazepines: How They Work and How to Withdrawal. Prof. C. H. Ashton. Revised August 2002 – Chapter 3, Pages 7/22 of online version).

(Differentiating Between Symptoms)

3.3.19 It has been asked how we can differentiate between symptoms of the original complaint and those of dependence. Admittedly, it can be very difficult to differentiate between these because, in some cases, the symptoms are very similar. This is why it is not possible to make any judgments simply based on analyzing a few symptoms. Rather, everything needs to be considered in context including the application of the DSM IV-TR criteria.

3.3.20 Generally speaking, if the drugs are achieving the desired effect, the patient's condition will no doubt improve. In cases of Benzodiazepine dependence, the patient will likely experience an initial settling of symptoms followed by symptom patterns consistent with tolerance (See Article 2.1). When this is then followed by a continual worsening of symptoms and the development of new symptoms during the treatment, it is suggestive of withdrawal symptoms; however, illness progression must also be considered (See 3.3.14). If the patient experiences an intensifying of these symptoms upon reduction (symptom rebound) together with the development of other new withdrawal symptoms, it is likely that the symptoms were due to dependence, as was in Wayne's case.

3.3.21 Further, when these symptom patterns are put into context of the overall clinical picture (See pages 11~12, Report One) including prescription history, the inability to work following the treatment and then the ability to return to work following drug rehabilitation etc. and the application of the DSM IV-TR (See Section Two above) including the unsuccessful attempts at reduction etc. it becomes clear that the worsening of symptoms and development of new symptoms during the course of treatment were most likely caused by dependence.

(Relevance of Anxiety Debate)

3.3.22 It must be made clear that the outcome of the debate regarding whether or not Wayne had an anxiety disorder does not alter the fact that he was Benzodiazepine dependent.

3.3.23 Anxiety disorders and Benzodiazepine dependence can and do coexist in some cases. Indeed many people who are prescribed Benzodiazepines do have an underlying anxiety related condition and this is sometimes why the drugs are prescribed to begin with. However, as previously mentioned, Benzodiazepines are highly addictive drugs and are only suitable for treatment lasting for no more than about two weeks because they in turn can cause anxiety.

3.3.24 To say that a patient was not dependent because they had an anxiety condition is unfounded and does not rule out the possibility of Benzodiazepine dependency. Anyone taking Benzodiazepines for any more than about 2 ~ 4 weeks is susceptible to developing tolerance and withdrawal, including people with anxiety disorders. Subsequently, the debate over whether or not Wayne had an anxiety disorder does not form grounds for ruling out these criteria.

3.4 Consistency of Previous Reports & Evidence

3.4.1 I understand there has been some concern expressed regarding the consistency of my previous reports in relation to the evidence (patient files). After having had the opportunity to view the patient files firsthand, I am able to confirm the following with regards to the symptoms history outlined in Section One my first report:

1. Article 1.4.8 is consistent with the Patient Questionnaire Form on page 2 of the [redacted] Medical Centre patient file (Evidence Koh A6).
2. Article 1.4.7 is consistent with Wayne's handwritten note to Dr. [redacted] (Evidence Koh A26).
3. Article 1.4.6 is consistent with Wayne's handwritten note to Dr. [redacted] (Evidence Koh A12).
4. Article 1.4.5 was based on Wayne's reports that he experienced an initial settling of symptoms - this is supported by the initial improvement of his muscle stiffness outlined on page 8 of Dr. [redacted]'s patient file (Evidence Otsu A1).
5. Article 1.4.4 is consistent with page 12 of Dr. [redacted]'s patient file (Evidence Otsu A1).
6. Article 1.4.3 is consistent with a summarized version of page 11 of Dr. [redacted]'s patient file, where most of the symptoms are basically different words for the same thing, i.e. dizziness (Evidence Otsu A1).
7. Article 1.4.2 was based on Wayne's reports that most of his work related stress symptoms outlined in Article 1.4.1 mostly disappeared after he changed jobs in April 2000 (See Articles 3.3.6~3.3.10 for comments on this).
8. Article 1.4.1 was based on Wayne's reports that he was experiencing work related stress symptoms, which is consistent with pages 12~13 of the [redacted] ENT patient file (See Articles 3.3.6~3.3.10 for comments on this).

NB: These symptoms contained in Section One of my first report are also consistent with Wayne's presentation to our service.

3.4.2 I note that there was some additional information contained in the patient files. However, none of this has any significant bearing on the application of the DSM IV-TR Criteria or the dependence diagnosis.

3.4.3 In the Q & A document, between Mr. [redacted] and me, dated 19th December 2008, I suggested a number of possible mechanisms for most of Wayne's symptoms outlined in sections 1.4.6 and 1.4.7 of my first report, and I also said that I was unable to comment further on some of Wayne's symptoms. This is because further information was needed at the time in order to be able to make a more objective decision.

However, the fact that many of these symptoms intensified during the reduction process and the fact that they are consistent with known Benzodiazepines withdrawal symptoms, as well as other adverse effects, or Benzodiazepine symptom clusters, remains unchanged. Please note that these were listed as possibilities only, and as I mentioned in my second report, there are numerous clusters of symptoms / syndromes related to Benzodiazepine use including; tolerance, dependence, withdrawal, symptom escape, symptom rebound, side-effects etc, and it is usual for them to overlap somewhat.

3.5 Future Reports and Possible Testimony

3.5.1 I understand there are 3 main disputes regarding Wayne's claim for compensation, as follows:

1. Dependence
2. Informed consent & monitoring
3. Long term effects / damages

(Future Reports)

3.5.2 Regarding (2) above, I understand that the informed consent and monitoring part of Wayne's claim was rejected at the initial hearing on the grounds that there was insufficient evidence / argument put forward with regards to this. Subsequently, I am happy to provide a report on informed consent and monitoring based on Wayne's case in relation to the World Health Organization's "Guide to good prescribing".

3.5.3 Regarding (3) above, I understand that there is a dispute over long term effects with regards to Wayne's post drug rehabilitation history. Subsequently, I am happy to provide a report on long term effects of Benzodiazepine use based on Wayne's case.

(Possible Testimony)

3.5.4 With regards to my availability for a possible testimony, I am happy to travel to Japan for a court date. However, the actual time will have to be confirmed in advance with my employer, which will require several months notice in advance.

NB: On top of having submitted several reports regarding (1) above, it is preferable to submit reports regarding (2) and (3) above as well in advance of any potential hearing date. This will allow time to get all of the facts straight based on the evidence in order to help provide the most accurate information possible. By doing so, all parties will have the opportunity to view the reasoning in advance, and therefore, be able to prepare any questions that they may have, which I am happy to respond to.

Also, please understand that preparing these reports takes time, as I also have work commitments at the hospital and there is also the need to relay information between Wayne and his lawyer between two different languages.

Summative Conclusion

1) Wayne showed signs of developing the early stages of tolerance following about 1.5 months of treatment.

2) This was further compounded by several more months of daily dosing, after which, Wayne developed several more new symptoms that were consistent with withdrawal and tolerance (following about 4~6 months of prescriptions).

3) It was around this time that Wayne's friends began voicing their concerns regarding his wellbeing.

4) Feeling concerned that his condition was deteriorating; Wayne reports that he tried unsuccessfully to stop his drug intake in late November 2000.

5) Soon after this attempt, Wayne returned to see Dr. [redacted] at the [redacted] Hospital on 13th December 2000 to request a re-referral to another hospital, showing an awareness that the drugs were possibly causing him harm.

6) Wayne then began to make a list of new symptoms, dated 18th December 2000, so that he could better convey his concerns with regards to his deteriorating condition to Dr. [redacted] Many of the symptoms contained in this list were consistent with withdrawal due to tolerance.

7) Subsequently, we can estimate that Wayne had likely developed Benzodiazepine dependence following about 4~6 months of treatment, which based on statistics, is a typical timeframe for dependence to form (See reference on page 13 of Report One).

8) Soon after changing hospitals, a reduction plan was negotiated with Dr. [redacted] In accordance with this plan, Wayne made a second unsuccessful attempt at reduction.

9) Following this attempt, Wayne decided to return to New Zealand, where following another unsuccessful attempt at stopping, he sought professional help from our service.

10) During the formal reduction program, his symptoms intensified again along with the development of other withdrawal symptoms.

11) Wayne recovered from most of his symptoms within about 3 months of completing the initial withdrawal phase of the reduction program. Other symptoms took up to 1 year to recover from gradually improving over time, which is suggestive of a protracted withdrawal syndrome.

12) Following completion of the reduction program, Wayne was able to make a gradual return to recreational activities, where he made significant gains in weight, strength and stamina, which was made apparent by his ability to work as an adventure tour guide and yardman.

13) He has since been able to make a return to living and working in Japan, and despite being under considerable more stress on this occasion with his ongoing case for compensation, he continues to maintain a much better state of health.

14) I have been informed that there were some questions raised with regards to what "dependence" actually is. Dependence does not simply refer to a state in which people find it difficult to stop taking the drugs. It is a severe illness, which can result in considerable mental and physical suffering for the patient, potentially causing significant damages to their livelihoods including work, family social life, and general wellbeing, as highlighted by Professor Ashton below.

"*Benzodiazepine withdrawal is a severe illness. The patients were usually frightened, often in intense pain, and genuinely prostrated. The severity and duration of the illness are easily underestimated by medical and nursing staff, who tend to dismiss the symptoms as "neurotic." In fact, through no fault of their own, the patients suffer considerable physical as well as mental distress.*"
(See Benzodiazepine Withdrawal: An Unfinished Story. Prof. C. H. Ashton. 1984, Page 12/13 of online version).

15) Based on the content of my previous reports and after having had the opportunity to view the patient files (evidence) firsthand, I am able to reconfirm that Wayne meets 5 criteria of the DSM IV-TR.